

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18337**
Registrar's No. **242**

FILED JUN 9 1944
Registration District No. **18337**

Primary Registration District No. **2001**

1. PLACE OF DEATH:

(a) County **Passey**
(b) City or town **Joplin**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **St. Johns**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day** (Specify whether years, months or days)
In this community **Non-Resident**

3. (a) PRINT FULL NAME **Myrtle Rosa Graham**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **James Graham** 6. (c) Age of husband or wife if alive **18 years**
7. Birth date of deceased **July 29 1898** (Month) (Day) (Year)

8. AGE: Years **45** Months **9** Days **11** If less than one day hr. min.

9. Birthplace **Bl.** (City, town, or county) **Mo.** (State or foreign country)

10. Usual occupation **Stomach**

11. Industry or business

12. Name **Christine Berger**
13. Birthplace **Germany** (City, town, or county) (State or foreign country)
14. Maiden name **Rosa Foster**
15. Birthplace **Ind.** (City, town, or county) (State or foreign country)

16. (a) Informant **Rose Cotton**
(b) Address **Joplin R. 1**
17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **5/10/1944** (Month) (Day) (Year)
(c) Place: burial or cremation **Joplin**

18. (a) Signature of funeral director **Frank Albison**
(b) Address **Joplin**
19. (a) **5-12-44** (Date received local registrar) (b) **John D. Sutherland** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Cherokee**
(c) City or town **Joplin** (If outside city or town limits, write "RURAL")
(d) Street No. **R.R. #1** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **10** year **1944** hour **10** minute **55** A.M.

21. I hereby certify that I attended the deceased from **May 9** 1944 to **May 10** 1944 that I last saw him alive on **May 9** 1944 and that death occurred on the date and hour stated above.

Immediate cause of death **Diabetes** Duration **Life**
Due to **Diabetic Coma** 2 days
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: **none** 61
Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)
While at work? (e) Means of injury
23. Signature **John D. Sutherland** (a. D. or other)
Add Date signed **5/10/44**

44-5-402)

JUN 12 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
Removed to Galena Kan.; Registered Apprentice No.....
working under my personal supervision. No. Emb-

Signed.....

Frank Allison
Kan

Licensed Embalmer No. 1321

P. O. Address Galena Kan

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.